

CMS Medicare Manual System

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Centers for Medicare & Medicaid
Services (CMS)

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CHANGE REQUEST 2333

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Red italicized font identifies new material.

Medicare Contractors Only: these instructions should be implemented within your current operating budget.

NEW/REVISED MATERIAL--EFFECTIVE DATE: October 25, 2002
IMPLEMENTATION DATE: October 25, 2002

Chapter 2, Section 4.1, Types of Fraud Alerts, clarifies the numbering of fraud alerts; changes the mailing address for National Medicare Fraud Alerts (NMFAs) to an email address; adds the Defense Criminal Investigation Service (DCIS) to the audience line; clarifies the sharing of NMFAs; and clarifies the mailing of Restricted Medicare Fraud Alerts (RMFAs).

Chapter 2, Section 4.5, Distribution of Alerts, clarifies the mailing of RMFAs and the emailing of NMFAs.

Chapter 2, Section 6, OIG Referrals and Appropriate FID Entries, clarifies case entries into the Fraud Investigation Database (FID).

Chapter 3, Section 8.3.3, Consent Settlement Instructions, corrects the Option numbers for Consent Settlements; changes SVRS to Statistical Sampling for Overpayment Estimation.

Chapter 3, Section 12.2.1, CMPs Delegated to CMS, revises bullet number 6 and 11 to change "also" to "only" in the last sentence enclosed in parenthesis.

Chapter 3, Section 12.3.2, Referrals to OIG, adds the last paragraph on misuse of the Medicare name, symbols, emblems, or other violations of § 1140 of the Social Security Act.

Exhibit 27, National Medicare Fraud Alert, adds DCIS to the audience line for Fraud Alerts.

Exhibit 28, Restricted Medicare Fraud alert, adds DCIS to the audience line for Fraud Alerts.

MANUALIZATION – EFFECTIVE/IMPLEMENTATION DATES: Not Applicable

Chapter 2, Sections 7-7.4, manualizes the Harkin Grantees PM, Transmittal No. AB-01-101.

Chapter 2, Section 7, Harkin Grantees: Complaint Tracking System, provides implementation instructions.

Chapter 2, Section 7.1, Harkin Grantee Project Description, describes contributions of senior volunteers who detect and report improprieties in Medicare activities.

Chapter 2, Section 7.2, Harkin Grantee: Tracking System Instructions, explains contractor responsibilities for collecting, tracking, and reporting administrative and monetary results of fraud and abuse complaints generated by Harkin Grantee State projects.

Chapter 2, Section 7.3, Data Collection, shows what information must be entered in the Winframe database fields.

Chapter 2, Section 7.4, Data Dissemination/Aggregate Report, requires the contractor to compile database information into an aggregate report and distributes it to coordinators.

Exhibits, manualizes Exhibit 32 and 33 from the Harkin Grantees PM, Transmittal No. AB-01-101.

Exhibit 32, Harkin Grantee Winframe Database Access and Operation Instruction, shows how to log on and use the system, illustrating the screens available.

Exhibit 33, Harkin Grantee Model Form, provides a template for the complaint referral form.

Chapter 2

Medicare Program Integrity Manual **Chapter 2 - Identifying Potential Errors and Potential Fraud**

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Chapter 2

4.1 – Types of Fraud Alerts -- (Rev. 32, 10-25-02)

There are two types of Fraud Alerts, National (nonrestricted) Medicare Fraud Alerts (NMFAs) and Restricted Medicare Fraud Alerts (RMFAs). These Alerts are produced and distributed to those listed on the audience line on the appropriate CMS letterhead. NMFAs are reproduced on blue border letterhead and RMFAs are reproduced on red border letterhead.

A – National Medicare Fraud Alerts (NMFA)

The most commonly issued Alert is the NMFA (refer to Exhibit 27 for the NMFA template). These Alerts do not identify specific providers or other entities suspected of committing fraud. They focus on a particular scheme or scam and are intended to serve as a fraud detection lead.

CMS CO issues a NMFA when the fraudulent or abusive activity is perceived to be, or has the potential for being, widespread, i.e., crossing contractor jurisdictions. These Alerts are numbered sequentially. Because CMS and OIG use a comparable numbering system, *CMS National Medicare Fraud Alerts are identified as CMS NMFA* followed by the Alert number appearing in the bottom left hand corner. OIG Alerts are identified by OIG, followed by the Alert number appearing in parenthesis at the bottom left hand corner. The National Medicare Fraud Alert is to be put on the blue border paper. The MFISs distribute both OIG and CMS Alerts to all agencies in their jurisdiction within 15 working days of receipt by the contractor .

Daft National Medicare Fraud Alerts to CO must be *password protected and emailed to vallen@cms.hhs.gov*.

A NMFA contains the following two disclaimers, in bold print:

“Distribution of this Fraud Alert is Limited to the Following Audience:

CMS Regional Offices, All Medicare Carrier and Intermediary Benefit Integrity Units, Program Safeguard Contractors, Medicare Integrity Program (MIP) Units, *Quality Improvement* Organizations, Medicaid Fraud Control Units, the Office of Inspector

General, *the Defense Criminal Investigation Service*, the Department of Justice, the Federal Bureau of Investigations, U.S. Attorney Offices, U.S. Postal Inspectors, Internal Revenue Service, State Surveyors, State Attorneys General, and the State Insurance Division. It is not intended to be used as a basis for the denial of any claim or adverse action against any provider. Such decisions must be based on facts independent of this Alert.”

“This Alert is provided for educational and informational purposes only. It is intended to assist interested parties in obtaining additional information concerning potential fraud and to alert affected parties to the nature of the suspected fraud. It is not intended to be used as a basis for denial of claims or any adverse action against any provider or supplier. Such decisions must be made based on facts developed independent of this Alert.”

The NMFA does not include a sanitized version, because it does not identify specific providers or entities. The sharing of NMFAs with individuals or groups that are not on the approved distribution list will be left to the discretion of the MFISs. However, if the MFISs choose to share the NMFAs beyond the approved list, the discovery and detection methodology sections shall not be included. These sections be disclosed only to the entities appearing on the audience line of the Fraud Alert.

B – Restricted Medicare Fraud Alerts (RMFA)

CMS issues a Restricted Fraud Alert when specific providers are identified as being suspected of engaging in fraudulent or abusive practices or activities. Contractors prepare this type of Alert (refer to Exhibit 28 for the RMFA template) when advising other Medicare carriers, intermediaries, *QIOs*, MFCUs, OIG, *DCIS*, FBI, or DOJ of a particular provider or providers, suspected of fraud. *These Alerts are numbered sequentially. Because CMS and OIG use a comparable numbering system, CMS Restricted Medicare Fraud Alerts are identified by CMS RMFA followed by the Alert number appearing in the bottom left hand corner.* Distribution is limited to Medicare contractors, CMS, *QIOs*, OIG/OI, *DCIS*, FBI, MFCUs, U.S. Postal Service, IRS, and the Offices of the U.S. Attorney. CMS CO will issue each MFIS one copy of a RMFA *along with a sanitized version.* Each MFIS will distribute said Alert to the contractor in their MFIS jurisdiction for reproduction on the red border letter provided to it. Contractors may issue local Restricted Alerts as they deem appropriate, subject to above distribution limits.

Until further notice, do not email Restricted Fraud Alert Drafts even if password protected:

Centers for Medicare & Medicaid Services
OFM/PIG/DBIL
Mail Stop C3-02-16
7500 Security Blvd.
Baltimore, MD 21244
Attention: Fraud Alert Lead

The envelope should be marked, “personal and confidential”, “do not open in mailroom”. The content of this Alert is not disclosable to the public even under the Freedom of Information Act. Public disclosure of information protected by the Privacy Act has serious legal consequences for

the disclosing individual. It is intended solely for the use of those parties appearing on the audience line. It contains the names and other identifying information of provider or suppliers who are suspected of fraud.

A Restricted Fraud Alert must contain the following disclaimer exactly as below:

THIS ALERT IS CONFIDENTIAL. It is not intended to be used as a basis for the denial of any claim or adverse action against any provider. Such decisions must be based on facts independent of this Alert.

Distribution is Limited to the Following Audience:

CMS Regional Offices, Medicare Carrier and Intermediary Benefit Integrity Units, Program Safeguard Contractors and Medicare Integrity Program Units, *Quality Improvement Organizations*, Medicaid Fraud Control Units, the Office of Inspector General, the *Defense Criminal Investigation Service*, the Department of Justice, the Federal Bureau of Investigation, U.S. Attorney Offices, U.S. Postal Inspector Offices, and the Internal Revenue Service.

NOTICE: THIS FRAUD ALERT CONTAINS CONFIDENTIAL INFORMATION EXEMPT FROM DISCLOSURE UNDER THE FREEDOM OF INFORMATION ACT. ITS CONTENTS MAY NOT BE REPRODUCED OR RELEASED TO ANY OTHER PARTY WITHOUT THE WRITTEN APPROVAL OF THE BENEFIT INTEGRITY STAFF. DISCLOSURE TO UNAUTHORIZED PERSONS IS PROHIBITED AND MAY BE IN VIOLATION OF THE CRIMINAL PROVISIONS OF THE PRIVACY ACT.

C – Alerts to CO

Contractors prepare one of these Alerts when:

- Contractors need to notify CMS of a scheme that is about to be publicized on the national media;
- The case involves patient abuse or large dollar amount (approximately \$1 million or more or potential for widespread abuse); or
- The issues involved are politically sensitive, e.g., congressional hearings are planned to accept testimony on a fraudulent or abusive practice.

The Alert is prepared and submitted in the same manner as a NMFA but the audience line reads, CO Only.

4.5 – Distribution of Alerts -- (Rev. 32, 10-25-02)

CMS issues the Alert to the MFISs for further distribution. *Approved NMFAs are sent through the electronic mail system and approved RMFAs are mailed.* Upon receipt of an approved Alert,

the MFIS will add their name and telephone number to the existing contact information on the Alert. They will then reproduce the Alert on their own stationary. MFISs are to distribute the Alert to the entities that appear on the audience line.

6 - OIG Referrals and Appropriate FID Entries -- (Rev. 32, 10-25-02)

The FID is a comprehensive nationwide on-line mainframe board system directed to fraud and abuse data accumulation.

The following agencies/organizations currently have access to the FID:

- Medicare Intermediaries and Carriers, including RHHIs and DMERCs;
- CMS;
- FBI;
- DOJ;
- Office of United States Attorney Generals;
- HHS OIG;
- Department of Labor OIG;
- Defense Contractor Investigation Service;
- Postal Inspection Service;
- Tennessee Valley Authority Inspector General;
- Medicare Program Safeguard Contractors;
- Medicaid Fraud Control Units; and
- Other Federal and State partners seeking to address program integrity concerns in judicial or State health care programs.

FID Background

The FID captures information on *both the* cases that are under development by the Medicare contractor *and the cases that* have been referred *by the contractor* to law enforcement for further investigation. A case exists when the contractor has substantiated an allegation that a provider, beneficiary, supplier, or other subject: (a) engaged in improper billing, (b) submitted improper claims with actual knowledge of their falsity; or (c) submitted improper claims with reckless disregard or deliberate ignorance of their truth or falsity. *While substantiation does not imply the proving of the information in a court of law, the definition of "contractor substantiation" does include any and all cases (regardless of dollar threshold or subject matter) where contractor staff verify to their own satisfaction that an allegation is likely to be true and further development of a case for potential referral to law enforcement is necessary.* Situations where numerous complaints are made, allegations forwarded by provider employees or ex-employees, and/or proactive data analysis producing clear evidence of wrongdoing are common examples of such situations.

FID Operational Issues

Individual complaints (statements alleging improper entitlement), simple overpayment recoveries (not including fraud), and medical review abuses are not commonly considered "cases" for purposes of FID entry and are more appropriately documented in complaint control systems.

Finally, the term "substantiated" does not imply the proving of the information in a court of law. Contractors do not prove fraud; such action is within the purview of the Department of Justice.

Immediate advisements are excepted from the requirement of substantiation for purposes of advising the OIG, and are not counted as referrals to the OIG until the issue is documented in the FID and formally referred.

The FID also reports other pertinent information. Some examples of the types of data included in the FID are:

- Subject of an investigation (i.e., physician, hospital, SNF, HHA, Comprehensive Outpatient Rehabilitation Facility (CORF), etc.);
- Allegation information/nature of the scheme;
- Status of the case;
- Disposition of a case (i.e., administrative action, prosecution, exclusion, settlement, etc.); and
- Contact information for contractor and/or law enforcement.

The FID also has monitoring/reporting capabilities, such as:

- The number of cases by subject, subject subtype, region, contractor, HCPCS, etc.;
- Length of time to close out a case;
- Number of cases referred to OIG/FBI;
- Number of cases accepted by OIG/FBI; and
- Dollar amount recovered through settlement, suspensions, and recoveries other than case settlements.

Initial Entry and Update Requirements

Once the contractor has substantiated that a case exists, it shall be entered into the FID within 30 days. After initial entry, cases shall be updated every 30 days while under development at the contractor, and every 90 days once the case has been referred to law enforcement.

The contractor shall enter OIG fraud referrals and cases currently under development by the contractor into the FID.

Open or pending fraud cases with the OIG as of 1/1/93, which involve contractor-substantiated allegations of fraud, should be entered into the FID and referred to law enforcement within 30 days of identification. It is the contractors' responsibility to follow up with the OIG and CMS RO on cases to assure that the referrals are not held for an extended time without action. If the OIG does not respond to the contractor within the 90-day time frame, the contractor should follow-up with OIG/OI to determine if they are going to accept the case. If the 90 days have been exceeded with no decision from the OIG, then the contractor should attempt one more contact with the OIG to render a decision.

If within a specified and reasonable time period (e.g., mutually agreed upon number of days) the OIG does not accept the case or is still unwilling to render a decision on the case, contractors should proceed with administrative action necessary to ensure the integrity of the Medicare Trust Funds. In all cases, contractors should institute all appropriate remedies available to them (e.g., overpayment recoupment, suspension, prepay review) and inform their respective regional office of their decision to proceed with administrative actions. Contractors should always develop and initiate appropriate administrative action prior to the elapsing of the 90 days and inform OIG of this proposed action prior to implementing the remedy.

Referrals accepted by OIG or FBI, are assigned an OIG/FBI case number. It is the responsibility of the contractor to obtain and enter the case number into the FID.

The contractor should revise information in the FID action field after the case is referred to the OIG/FBI. Any actions taken by law enforcement, (e.g., indictments, searches and seizures,

warrants) as well as contractor corrective/administrative actions should all be entered into the FID. If the contractor is not able to obtain status on cases referred to law enforcement, this should be brought to the attention of the CMS RO and/or CMS CO.

To restate, Medicare benefit integrity unit managers need to ensure that their referrals are handled according to OIG procedures (i.e., the referral is reviewed, accepted or rejected, or referred to another law enforcement agency within 90 calendar days of the referral). It is the contractors' responsibility to follow up on cases to assure that the referrals are not held for an extended period without action.

The narrative section on the FID should clearly identify any case development being done by the contractor. Also, the sooner a comprehensive case is entered into FID, the more efficiently other contractors, CMS, and law enforcement agencies can react to the investigation and perform related trend data analysis.

The contractor should enter cases that are initiated and referred by law enforcement into the FID within 30 days of law enforcement approval, *and update the FID every 90 days*. Absent their objections, and with their input, the case should go in the FID. However, it must be clear in the entry that the "case" came from law enforcement, not the contractor, and should not be counted as a contractor referral. Contractors should enter as much information as possible, and in their possession. This instruction is given with the understanding that the case did not result from contractor action and the realization that the contractor may not have information for some/many data fields. Should you become aware of any sensitive law enforcement information (e.g., on-going video surveillance, a planned raid by law enforcement, outstanding arrest warrants, etc.), this should not be entered in the FID, unless, after the fact and approved by the applicable OIG/FBI case agent. Also, do not enter the names of agents in the case description field. This information belongs in the "contact" portion of the case screens.

In addition to contacting OIG regarding the status of a case, there is a need for the contractor to actively keep track of his or her referral(s). This means that FID entries should address:

- Contacting the FBI or Assistant United States Attorney (AUSA) regarding their actions on case;
- Updating the action screen to capture subsequent law enforcement referrals (e.g., OIG declines case, contractor refers case to FBI, FBI accepts case);
- Keeping apprised of MR/Provider Audit and Reimbursement actions if they are taking actions on a case;
- Updating the amount being withheld, denied, or paid;
- Entering information on convictions /sentences in the action screen; and

- Revising the narrative screens to incorporate any updated information from the action screens.

If problems are encountered which undermine these activities, they should be discussed with BI staff from the CMS RO. The contractor should document all major actions taken in the Action/Disposition screen (e.g., overpayment calculated, payment suspension imposed, prepay initiated/removed, etc.). In addition, it is extremely important to document in the FID any consultations with law enforcement as well as administrative actions and associated monetary assessments by the contractor. Contractors are responsible for providing such documentation.

It is not appropriate for an OIG or FBI Agent, or an AUSA to request that a contractor not enter a contractor developed case, or update the FID on a related contractor developed case. Contractors should inform law enforcement agents making such requests that you are required by CMS to maintain the FID and that you do not have the discretion to do otherwise. Further, advise them to contact the CMS RO or their headquarters if the matter persists.

Cases not referred must be updated every 30 days and every 90 days once it has been referred.

Cases can be deleted from the FID only by users with the "File Manager" (system administrator) designation. As applicable and necessary, CMS CO and RO staff will contact and discuss with the contractor the need to correct and/or delete a case from the database. In the event that a contractor decides that a case should be deleted from the FID, this information should be forwarded to the CMS RO, CMS CO FID contacts, or BI Coordinator for approval.

Duplicate FID Cases

A duplicate case exists when any given contractor enters a provider, supplier, or beneficiary as the subject of an investigation more than once, absent different allegations or other differentiating criteria requiring a separate referral.

It is not considered a duplicate case if *multiple* contractors enter cases for the same provider as the subject of an investigation. These cases, however, must reflect a coordinated effort by all contractors involved and investigating the provider. Case numbers must be referenced and the case description summaries must reflect this coordination. The FID now has the capability of cross-checking for related cases.

If a case is being developed on a provider that was already the subject of a closed case, a new case should be opened. The closed case, however, should be mentioned in the case narrative screen and cross-referenced to the old FID case number.

The case target, whether entity or individual, should be entered as the subject of the FID case. Any and all related providers, suppliers, or beneficiaries, who are a subject of the case, should then be identified under AKAs, DBAs, and Affiliates. However, if the individuals are the primary subjects/targets of the investigation and independent cases are made against them, then individual cases should be established in the FID with corresponding individual referrals to OIG.

It is the contractor Benefit Integrity Unit's responsibility to check for potential duplicate entries of FID cases.

Documenting an Overpayment in the FID

Under the redesigned FID, we expect a separate data field for "Estimated Overpayment." Redesigned action screens also record "Overpayment Assessed" and "Overpayment Recouped." However, until such time as the redesigned FID is released, the contractor should enter the best estimate of the overpayment figure. As the substantiated allegation progresses, the contractor will replace the estimated loss with the actual loss. If the overpayment is recovered before the case is closed, the amount recovered should be entered in the applicable field, and in addition, should be captured as a FID "action". If the recovery occurs after the case is closed, the contractor must still update the FID with the recovered amount, updating both the "estimated overpayment" and "action" fields. These fields may continue to be updated even though the case is "closed." A case is closed when no further action is required by the contractor and law enforcement.

Administrative Action

In addition to the referral of cases to the OIG, contractors should identify and take corrective action to prevent future improper payment (for example, by denying false claims, placing the provider or suppliers' claims on pre-payment review, post-pay review, payment suspension, or CMPs). The contractor should take all appropriate action in order to prevent any further payment of inappropriate claims and to recover any overpayments that may have already been made, regardless of whether the OIG/FBI accepts or declines the case referral. Contractor action may vary from case to case. In one instance, it may be appropriate to suspend payment pending further development of the case and calculation of an overpayment. In another instance, suspending payment may alert the provider to detection of the fraudulent activity and undermine a covert operation already underway, or actively being planned, by Federal law enforcement.

To be certain that the contractor intervention matches the alleged situation, it is important to consult with the CMS RO, and as applicable (e.g., when law enforcement has an open investigation), the OIG, FBI, and both the civil and criminal divisions in the U.S. Attorney's office, before implementing payment suspensions, overpayment recoveries, etc. Where there is reliable evidence of fraud and a law enforcement referral pending, or already made, the contractor must advise the CMS RO and the agency that has the lead for the investigation prior to initiating the administrative action.

All cases where the allegations of fraud have been substantiated should be referred to the OIG. The OIG has 90 calendar days to accept the referral, refer the case to the Department of Justice (e.g., FBI, AUSA, etc.), return the case for additional development, or decline the case. Acceptance or rejection of the referral, like all other significant contacts with the OIG, should be documented in the FID. The OIG has 90 calendar days to accept the referral, refer the case to the Department of Justice (e.g., FBI, AUSA, etc.), or reject the case.

Immediate Advisement to the OIG

The contractor must immediately "advise" OIG when allegations concerning one or more of the characteristics listed below are received:

- Indications of contractor employee fraud (e.g., altering claims data or manipulating it to create a payment preferential treatment to certain providers; improper preferential treatment in collection of overpayments; embezzlement);
- Current provider employee who personally calls or visits the contractor and has information or evidence fraud is currently ongoing. Notification to law enforcement should be at the time of the occurrence whenever possible;
- Allegations of kickbacks, bribes; and
- A crime by a Federal employee.

When an immediate "advisement" is required, all available information must be forwarded, unless otherwise directed by OIG. However, the initial forwarding of the applicable information does not equate to the contractor completing the full referral "package" as defined in the PIM (EXHIBIT 16.1), and does not equate to a case referral to law enforcement. Do not enter the information into the FID, unless directed to do so by the OIG.

The "case" information is to be entered into the FID concurrent with, or within 30 days after, the "advisement" if the contractor substantiates the allegation, or upon such time the OIG accepts the "advisement" and opens a case.

Contractors should not expend resources attempting to substantiate the allegation until so directed by CMS and/or the OIG. For example, if a contractor receives an allegation of kickbacks, the contractor should immediately advise the OIG of the allegation, but not initiate an independent contractor query until requested to do so by the OIG and guidance on the parameters of the query are provided by the OIG. In this example, neither CMS nor its contractors have the authority (jurisdiction) to investigate allegations of kickbacks, thus "immediate advisement" to OIG.

OIG Declination

When the OIG formally declines a referral and does not refer the case to the FBI, the contractor is free to refer the case to another law enforcement agency (e.g., FBI, Postal, IRS, etc.). However, when this occurs, it is considered an update reflecting a subsequent action, not a new referral to law enforcement. As a general rule, subsequent referrals to other law enforcement agencies do not count as new case entries in the FID, nor are they counted for workload purposes as new referrals to law enforcement.

MFIS and the FID

MFISs receive training on how to input and maintain cases in the FID. The intent is to use MFISs as "FID experts" and points of contact for questions and comments on the FID. The MFISs should be responsive to FID questions from carriers and intermediaries and law enforcement personnel within their jurisdiction.

MFISs should regularly share FID information and analysis (e.g., FID system reports) with the BI unit manager, or their designee, for their applicable jurisdiction. The MFIS serves as a resource to CMS on the FID including FID training. While the MFIS should not enter cases into the FID or monitor FID quality, if the MFIS detects any inaccuracies or discrepancies they should notify the respective contractor staff and/or management. Upon request, the MFIS will furnish FID reports to the BI unit manager within their jurisdiction.

FID Access

If you have never applied for access to the FID system and require authorization, an "Application for Access to CMS Computer Systems" must be completed, submitted and approved. This form may be acquired from the appropriate RACF Group Administrator for all CMS central and regional office and contract users, or in the CMS Division of Benefit Integrity and Law Enforcement Liaison for all law enforcement personnel or other users.

For those individuals who have received prior authorization, but are experiencing authorization lapses or password problems, the same contacts referenced above should be contacted. Internet access problems are appropriately directed to CMS's Division of Systems and Network Engineering at CMS Central Office while software or other connection problems are handled by the CMS Action Desk at (410) 786-2580.

Persistent problems or instances where corrective actions cannot be made, should be forwarded to the CMS Division of Program Integrity Operations. The Division of Benefit Integrity and Law Enforcement Liaison is also the direct point of contact for special extracts and reporting options as well as access submissions of "nonstandard" users.

7 – Harkin Grantees: Complaint Tracking System -- (Rev. 32, 10-25-02)

This section provides instructions for implementing the Harkin Grantee Tracking System (HGTS).

7.1 – Harkin Grantee Project Description -- (Rev. 32, 10-25-02)

The Harkin Grantees (named after Senator Tom Harkin) are part of a broad anti-fraud and abuse initiative to combat waste, fraud, and abuse within the Medicare program. The anti-abuse initiative is supported by the partnership between the Department of Health and Human Services, Office of Inspector General, and the Administration on Aging.

The Harkin Grantees are senior volunteers who focus on detecting and reporting fraudulent or improper Medicare activities primarily in home health care, nursing facilities, hospice, and among durable medical equipment suppliers.

7.2 – Harkin Grantee Tracking System Instructions -- (Rev. 32, 10-25-02)

The Medicare contractors are responsible for collecting, tracking and reporting the administrative and monetary results of fraud and abuse complaints generated by the Harkin Grantee state projects. The contractors are responsible for developing aggregate reports and

making the reports available to the Harkin Grantee state project coordinators every six months. The contractors are expected to disseminate only the information that is collected for the aggregate reports to the Harkin Grantee state project coordinators.

The MFIS (Medicare Fraud Information Specialists) play a role in outreach efforts with the Harkin Grantees and should be available to explain the general content of the aggregate reports.

7.3 – Data Collection -- (Rev. 32, 10-25-02)

The Medicare contractors must designate a person to input the complaint information into the HGTS database located on the Winframe system. The contractors enter data on a continuing basis related to complaints generated by the Harkin Grantee state projects. (Winframe database access and operation instructions are included with this document as Exhibit 32.) For access to the CMS Winframe system, e-mail Scott Wakefield at Swakefied@cms.hhs.gov.

The Harkin Grantees report their complaints according to their usual procedure; however, the complaint form must clearly identify that the complaint is coming from a Harkin Grantee State project and the State project number as noted on the suggested model form (see Exhibit 33).

Upon receiving the Harkin Grantee complaints, the Medicare contractor enters the following information into the Winframe database fields:

<i>Project number</i>	<i>Medicare contractor number</i>
<i>Date of report</i>	<i>Overpayment Identified</i>
<i>Provider number</i>	<i>Overpayment Recovered</i>
<i>Provider name</i>	<i>Fraud Investigation Database number</i>
<i>Provider city</i>	<i>Action Taken</i>
<i>Provider state</i>	<i>Further Explanation</i>

7.4 – Data Dissemination/Aggregate Report -- (Rev. 32, 10-25-02)

The contractor compiles information in the database into an aggregate report. The contractor distributes the aggregate report to the Harkin Grantees State project coordinators every 6 months.

Chapter 3

8.3.3 – Consent Settlement Instructions -- (Rev. 32, 10-25-02)

The consent settlement is an appropriate tool to modify a provider's billing practice while limiting contractor costs in monitoring provider practice patterns. Consent settlement documents carefully explain, in a neutral tone, what rights a provider waives by accepting a consent settlement. Also, the documents must explain in a neutral tone the consequences of not accepting a consent settlement. A key feature of a consent settlement is a binding statement that the provider agrees to waive any rights to appeal the decision regarding the potential

overpayment. The consent settlement agreement must carefully explain this to ensure that the provider is knowingly and intentionally agreeing to a waiver of rights. A consent settlement correspondence must contain:

- A complete explanation of the review and the review findings;
- A thorough discussion of §§1879 and 1870 determinations where applicable; and
- The consequences of deciding to accept or decline a consent settlement.

When offering a provider a consent settlement, contractors may choose to present the consent settlement letter to the provider in a face-to-face meeting. The consent settlement correspondence describes the three options available to the provider.

A – Option 1 – Acceptance of Potential Projected Overpayment

Providers selecting Option 1 agree to refund the entire limited projected overpayment amount without submitting additional documentation. These providers forfeit their right to appeal the adjudication determinations made on the sampled cases and the potential projected overpayment that resulted from extrapolating to the universe. For providers who elect Option 1, do not audit any additional claims for the service under review within the time period audited. (If desired, waive Option 1.)

B – Option 2 – Acceptance of Capped Potential Projected Overpayment

Providers selecting Option 2 agree to submit additional pre-existing documentation. Review this additional documentation and adjust the potential projected overpayment amount accordingly. Do not audit any additional claims for the service under review within the time period audited for providers who elect Option 2.

C – Option 3 – Election to Proceed to *Statistical Sampling for Overpayment Estimation*

If a provider fails to respond, this option is selected by default. For providers who select this option knowingly or by default, thereby rejecting the consent settlement offer and retaining their full appeal rights, contractors shall:

- Notify the provider of the actual overpayment and refer to overpayment recoupment staff. (See PIM Chapter 3 §8); and
- Initiate *statistical sampling for overpayment estimation* of the provider's claims for the service under review. (See PIM Chapter 3 §8.3.2)

If the review results in a decision to recoup overpayment through the consent settlement process, the consent settlement must have been initiated within 12 months of the selection process.

A sample of Consent Settlement Documents can be found in Exhibit 15.

12.2.1 – CMPs Delegated to CMS -- (Rev. 32, 10-25-02)

The following is a brief description of authorities from the Social Security Act:

- Section 1806 (b)(2)(B)--Any person or entity that fails to provide an itemized statement describing each item or service requested by a Medicare beneficiary.
- Section 1833(h)(5)(D)--Any person billing for a clinical diagnostic laboratory test, other than on an assignment-related basis. This provision includes tests performed in a physician's office but excludes tests performed in a rural health clinic. (This violation may also cause an assessment and an exclusion.)
- Section 1833(i)(6)--Any person billing for an intraocular lens inserted during or after cataract surgery for which payment may be made for services in an ambulatory surgical center.
- Section 1833(q)(2)(B)--When seeking payment on an unassigned basis, any entity failing to provide information about a referring physician, including the referring physician's name and unique physician identification number. (This violation may also cause an exclusion.)
- Sections 1834(a)(11)(A) and 1842(j)(2)--Any supplier of durable medical equipment charging for covered items (furnished on a rental basis) after the rental payments may no longer be made (except for maintenance and servicing) as provided in §1834(a)(7)(A) of the Act. (This violation may also cause an assessment and an exclusion.)
- Section 1834(a)(17)(C)--Unsolicited telephone contacts by any supplier of durable medical equipment to Medicare beneficiaries regarding the furnishing of covered services. (This violation may *only* cause an exclusion.)
- Sections 1834(a)(18)(B) and 1842(j)(2)--Any durable medical equipment supplier that fails to make a refund to Medicare beneficiaries for a covered item for which payment is precluded due to an unsolicited telephone contact from the supplier. (This violation may also cause an assessment and an exclusion.)
- Sections 1834(b)(5)(C) and 1842(j)(2)--Any nonparticipating physician or supplier that charges a Medicare beneficiary more than the limiting charge as specified in §1834(b)(5)(B) of the Act for radiologist services. (This violation may also cause an assessment and an exclusion.)
- Sections 1834(c)(4)(C) and 1842(j)(2)--Any nonparticipating physician or supplier charging a Medicare beneficiary more than the limiting charge for mammography screening, as specified in §1834(c)(3) of the Act. (This violation may also cause an assessment and an exclusion.)

- Sections 1834(h)(3) and 1842(j)(2)--Any supplier of durable medical equipment, prosthetics, orthotics, and supplies charging for a covered prosthetic device, orthotic, or prosthetic (furnished on a rental basis) after the rental payment may no longer be made (except for maintenance and servicing). (This violation may also cause an assessment and an exclusion.)
- Section 1834(h)(3)--Unsolicited telephone contacts by any supplier of durable medical equipment, prosthetics, orthotics to Medicare beneficiaries regarding the furnishing of prosthetic devices, orthotics, or prosthetics. (This violation may *only* cause an exclusion.)
- Section 1834(j)(2)(A)(iii)--Any durable equipment supplier that completes the medical necessity section on the certificate of medical necessity or fails to provide the fee schedule amount and the supplier's charge for the medical equipment or supply prior to distributing the certificate to the physician.
- Sections 1834(j)(4) and 1842(j)(2)--Any supplier of durable medical equipment, prosthetics, orthotics, and supplies that fails to make refunds in a timely manner to Medicare beneficiaries (for items or services billed on a nonassigned basis) if the supplier does not possess a Medicare supplier number, if the item or service is denied in advance, or if the item or service is determined not to be medically necessary or reasonable. (This violation may also cause an assessment and an exclusion.)
- Sections 1834(k)(6) and 1842(j)(2)--Any practitioner or other person that bills or collects for outpatient therapy services or comprehensive outpatient rehabilitation services on a non-assigned basis. (This violation may also cause an assessment and an exclusion.)
- Section 1842(b)(18)(B)--For practitioners specified in §1842(b)(18)(C) of the Act (physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, certified nurse-midwives, clinical social workers, and clinical psychologists), any practitioner billing (or collecting) for any services on a non-assigned basis. (This violation may also cause an assessment and an exclusion.)
- Section 1842(k)--Any physician presenting a claim or bill for an assistant at cataract surgery performed on or after March 1, 1987. (This violation may also cause an assessment and an exclusion.)
- Section 1842(l)(3)--Any non-participating physician who does not accept payment on an assigned basis and who fails to refund beneficiaries for services that are not reasonable or medically necessary or are of poor quality. (This violation may also cause an assessment and an exclusion.)
- Section 1842(m)(3)--Any nonparticipating physician billing for an elective surgical procedure on a non-assigned basis, charges at least \$500, fails to disclose charge and coinsurance amounts to the Medicare beneficiary prior to rendering the service; and fails to refund any amount collected for the procedure in excess of the charges recognized and approved by the Medicare program. (This violation may cause an assessment and an exclusion.)

- Section 1842(n)(3)--Any physician billing diagnostic tests in excess of the scheduled fee amount. (This violation may cause an assessment and an exclusion.)
- Section 1842(p)(3)(A)--Any physician that fails to promptly provide the appropriate diagnosis code or codes upon request by CMS or a carrier on any request for payment or bill submitted on a non-assigned.
- Section 1842(p)(3)(B)--Any physician failing to provide the diagnosis code or codes after repeatedly being notified by CMS of the obligations on any request for payment or bill submitted on a non-assigned basis. (This violation is only subject to an exclusion.)
- Section 1848(g)(1)(B)--Any nonparticipating physician, supplier, or other person who furnishes physicians' services and bills on a non-assigned basis; or collects in excess of the limiting charge; or fails to make an adjustment or refund to the Medicare beneficiary. (This violation may cause an assessment and an exclusion.)
- Section 1848(g)(3)--Any person billing for physicians' services on a non-assigned basis for a Medicare beneficiary who is also eligible for Medicaid (these individuals include qualified Medicare beneficiaries). This provision applies to services furnished on or after April 1, 1990. (This violation may cause an assessment and an exclusion.)
- Section 1848(g)(4)--Any physician, supplier, or other person (except one excluded from the Medicare program) that fails to submit a claim for a beneficiary within one year of providing the service; or imposes a charge for completing and submitting the standard claims form. (This violation may cause an exclusion.)
- Section 1862(b)(5)(C)--Any employer who (before October 1, 1998) fails to provide an employee's group health insurance coverage information to the Medicare contractor.
- Section 1862(b)(6)(B)--Any entity that fails to complete a claim form relating to the availability of other health benefit plans; or provides inaccurate information relating to the availability of other health plans on the claim form.
- Section 1877(g)(5)--Any person failing to report information concerning ownership, investment, and compensation arrangements. (This violation may cause an assessment and an exclusion.)
- Section 1879(h)--Any durable medical equipment supplier (including a supplier of durable medical equipment, prosthetic devices, prosthetics, orthotics, and supplies) failing to make refunds to Medicare beneficiaries for items or services billed on an assigned basis if the supplier did not possess a Medicare supplier number; if the item or service is denied in advance; or the item or service is determined to be not medically necessary or reasonable. (This violation may cause an assessment and an exclusion.)

- Section 1882(a)(2)--Any person who issues a Medicare supplemental policy that has not been approved by the State regulatory program or does not meet Federal standards. (This violation may cause an assessment and an exclusion.)
- Section 1882(p)(8)--Any person who sells or issues nonstandard Medicare supplemental policies. (This violation may cause an assessment and an exclusion.)
- Section 1882(p)(9)(C)--Any person who sells a Medicare supplemental policy and fails to make available the core group of basic benefits as part of its product line; or fails to provide the individual (before the sale of the policy) an outline of coverage describing the benefits provided by the policy. (This violation may cause an assessment and an exclusion.)
- Section 1882(q)(5)(C)--Any person who fails to suspend a Medicare supplemental policy at the policyholder's request (if the policyholder applies for and is determined eligible for Medicaid); or automatically reinstate the policy as of the date the policyholder loses medical assistance eligibility (and the policyholder provides timely notice of losing his or her Medicaid eligibility). (This violation may cause an assessment and an exclusion.)
- Section 1882(r)(6)(A)--Any person that fails to refund or credit as required by the supplemental insurance policy loss ratio requirements. (This violation may cause an assessment and an exclusion.)
- Section 1882(s)(4)--Any issuer of a Medicare supplemental policy that does not waive any time periods applicable to pre-existing conditions, waiting periods, elimination periods, or probationary periods if the time periods were already satisfied under a preceding Medicare policy; or denies a policy, conditions the issuance or effectiveness of the policy, or discriminates in the pricing of the policy based on health status or other criteria. (This violation may cause an assessment and an exclusion.)
- Section 1882(t)(2)--Any issuer of a Medicare supplemental policy failing to provide medically necessary services to enrollees through the issuer's network of entities; imposes premiums on enrollees in excess of the premiums approved by the State; acts to expel an enrollee for reasons other than nonpayment of premiums; or does not provide each enrollee at the time of enrollment with specific information regarding policy restrictions; or fails to obtain a written acknowledgment from the enrollee of receipt of the information. (This violation may cause an assessment and an exclusion.)

12.3.2 – Referrals to OIG -- (Rev. 32, 10-25-02)

Upon discovery of any case that may implicate any of the OIG's delegated CMP authority, regardless of whether there is any other pending activity, or whether the fraud case was closed, the contractor shall contact the OIG/OI Field Office to discuss the potential case. If this contact results in a referral, the contractor shall follow the same referral format as described in Chapter 3, Section 10.1.4 of the PIM. If a referral is not made or a referral is declined, the contractor shall consider other administrative remedies, which, at a minimum, may include revocation of

assignment privileges, establishing prepayment or postpayment medical reviews, and referral of situations to State Licensing Boards or Medical/Professional Societies, where applicable. In all situations where appropriate Medicare payments have been identified, contractors shall initiate the appropriate steps for recovery.

The contractor shall send to the OIG all cases, as appropriate, where an excluded provider or individual has billed or caused to be billed to the Medicare or Medicaid program for the furnishing of items or services after exclusion. Such misconduct is sanctionable under §1128A(a)(C)(1) of the Social Security Act.

The contractor shall send to the OIG all cases where the contractor believes that misuse has occurred of the "Medicare" name, symbols, emblems, or other violations as described in Section 1140 of the Social Security Act and in 42 C.F.R., Section 1003.102(b)(7). All such cases are to be sent to the following OIG address:

*Chief, Administrative Litigation Branch, OIG-OCIG
Room 5527
330 Independence Avenue, SW
Washington, D.C. 20201*

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Exhibit 27 - National Medicare Fraud Alert -- (Rev. 32, 10-25-02)

National Medicare Fraud Alert Template

Date

Distribution of this Fraud Alert is Limited to the Following Audience: CMS Regional Offices, All Medicare Carrier and Intermediary benefit integrity units, Program Safeguard Contractors, Medicare Integrity Program (MIP) Units, Peer Review Organizations, Medicaid Fraud Control Units, the Office of Inspector General, <i>the Defense Criminal Investigation Service</i> , the Department of Justice, the Federal Bureau of Investigation, U.S. Attorney Offices, U.S. Postal Inspectors, Internal Revenue Service, State Surveyors, State Attorneys General, and the State Insurance Division
--

SUBJECT:

ACTIVITY:

SOURCE:

DISCOVERY:

DETECTION:

FID CASE (S):

STATUS:

CONTACT:

THIS ALERT IS PROVIDED FOR EDUCATIONAL AND INFORMATIONAL PURPOSES ONLY. IT IS INTENDED TO ASSIST PARTIES IN OBTAINING ADDITIONAL INFORMATION CONCERNING POTENTIAL FRAUD AND ABUSE AND TO ALERT AFFECTED PARTIES TO THE NATURE OF THE SUSPECTED FRAUD. IT IS NOT INTENDED TO BE USED AS A BASIS FOR DENIAL OF CLAIMS OR ANY ADVERSE ACTION AGAINST ANY PROVIDER OR SUPPLIER. SUCH DECISIONS MUST BE BASED ON FACTS DEVELOPED INDEPENDENT OF THIS ALERT.

Exhibit 28 - Restricted Medicare Fraud Alert -- (Rev. 32, 10-25-02)

RESTRICTED MEDICARE FRAUD ALERT TEMPLATE

THIS ALERT IS CONFIDENTIAL. It is not intended to be used as a basis for the denial of any claim or adverse action against any provider. Such decisions must be based on facts independent of this alert.

Distribution is Limited to the Following Audience:

CMS Regional Offices, Medicare Carrier and Intermediary benefit integrity units, Program Safeguard Contractors and Medicare Integrity Program Units, Peer Review Organizations, Medicaid Fraud Control Units, the Office of Inspector General, *the Defense Criminal Investigation Service*, the Department of Justice, the Federal Bureau of Investigation, U.S. Attorney Offices, U.S. Postal Inspector Offices, and the Internal Revenue Service.

SUBJECT:

ACTIVITY:

SOURCE:

DISCOVERY:

DETECTION:

FID CASE (S):

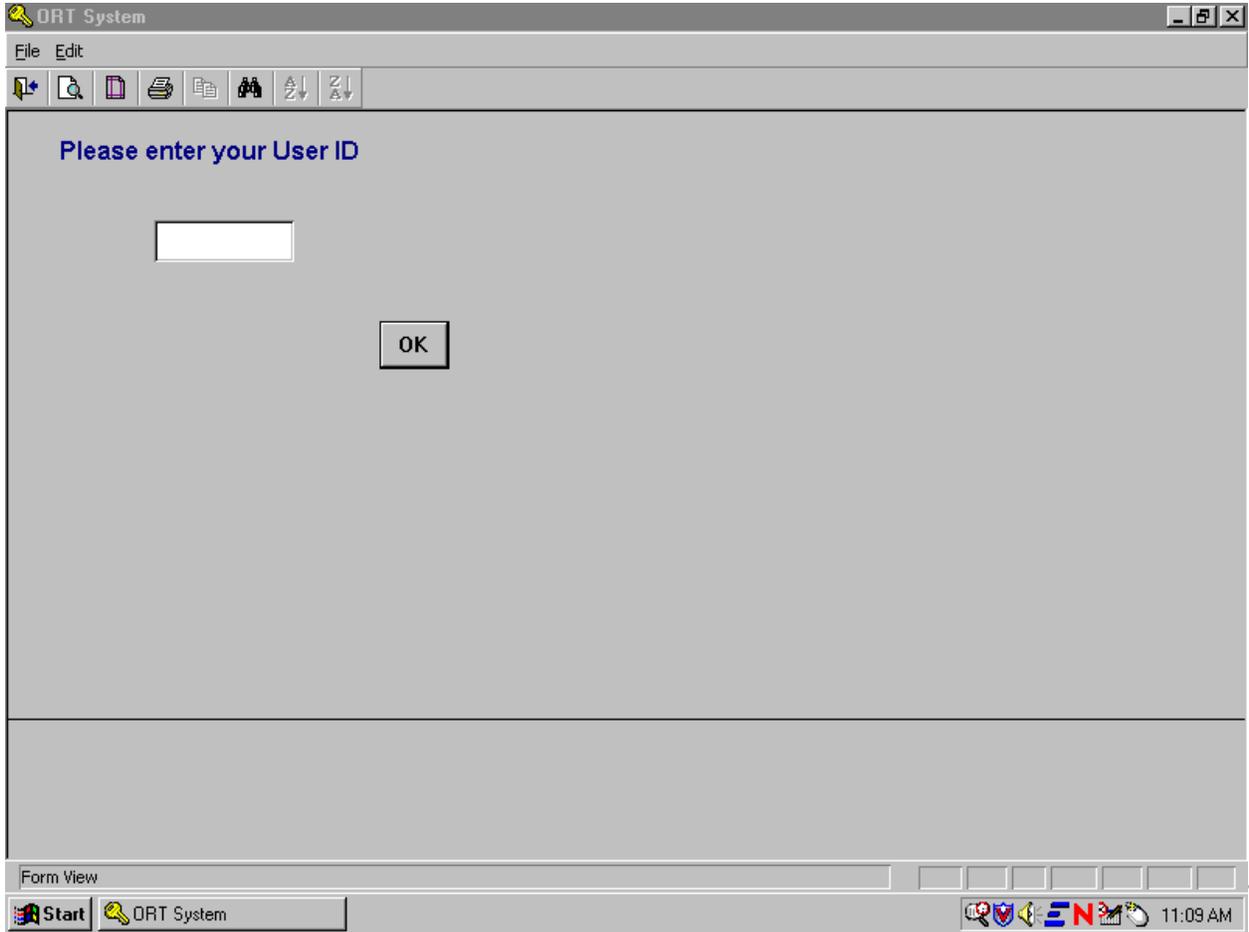
STATUS:

CONTACT:

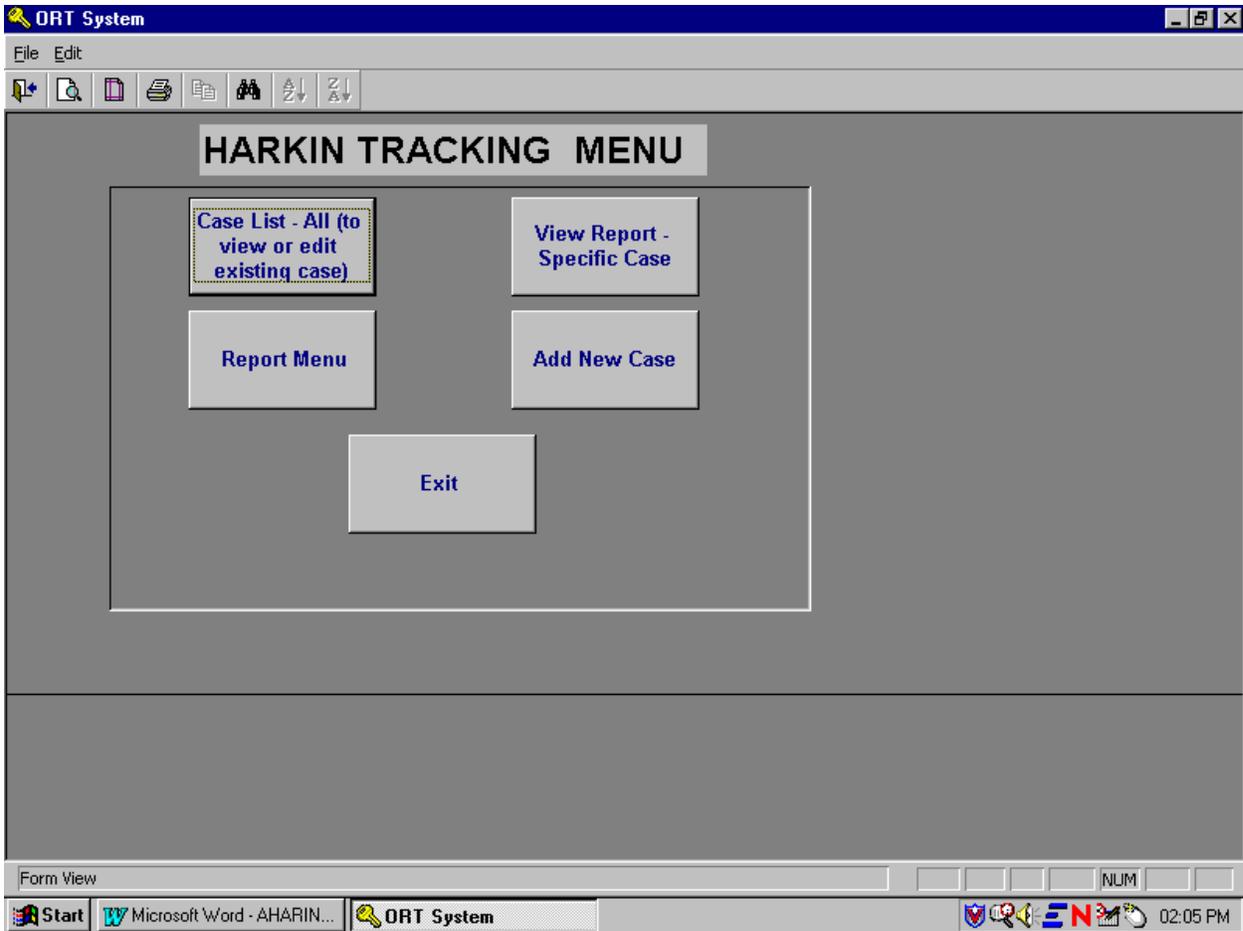
NOTICE: THIS FRAUD ALERT CONTAINS CONFIDENTIAL INFORMATION EXEMPT FROM DISCLOSURE UNDER THE FREEDOM OF INFORMATION ACT PURSUANT TO EXEMPTION (b) (2), (b)(5) AND (b)(7)(E) OF THE FOIA. ITS CONTENTS SHOULD NOT BE REPRODUCED OR RELEASED TO ANY OTHER PARTY WITHOUT WRITTEN APPROVAL OF THE BENEFITS INTEGRITY STAFF. DISCLOSURE TO UNAUTHORIZED PERSONS IS PROHIBITED AND MAY BE IN VIOLATION OF THE CRIMINAL PROVISIONS OF THE PRIVACY ACT.

THIS ALERT IS PROVIDED FOR EDUCATIONAL AND INFORMATIONAL PURPOSES ONLY. IT IS INTENDED TO ASSIST PARTIES IN OBTAINING ADDITIONAL INFORMATION CONCERNING POTENTIAL FRAUD AND ABUSE AND TO ALERT AFFECTED PARTIES TO THE NATURE OF THE SUSPECTED FRAUD. IT IS NOT INTENDED TO BE USED AS A BASIS FOR DENIAL OF CLAIMS OR ANY ADVERSE ACTION AGAINST ANY PROVIDER OR SUPPLIER. SUCH DECISIONS MUST BE BASED ON FACTS DEVELOPED INDEPENDENT OF THIS ALERT.

***Exhibit 32 – Harkin Grantee Winframe Database Access and Operation Instructions –
(Rev. 32, 10-25-02)***



To log on to the Harkin Tracking system, enter your user ID on the text box and click on OK. If your user ID is not profiled in the system database or you accidentally entered the wrong user ID, the message box will read, you do not have access to the system, please verify your user ID or contact the system administrator. At this point, click on OK to go to the next screen. If you are sure that you have entered your ID correctly and still have trouble accessing the system, contact Scott Wakefield at (410) 786-4301, or Binh Nguyen at (410) 786-3682.



Once you are in the system, the **Harkin Tracking Menu** is the first screen that will be displayed. **Users who do not have Write access will not see the Add New Case function.** The following are descriptions of each function:

1. **Case List - All (to view or edit existing case)** - Clicking on this will allow you to view all the case listings in order by case number.
2. **Report Menu** - Clicking on this will open the Report Menu that allows you to view a case report in either a Details or Tabular format. These reports reflect criteria such as date, state, provider number etc.
3. **View Report-Specific Case** - Click on this button if you want to access a specific report by case number.
4. **Add New case** - You will only see this function button if you have Read & Write access. When accessed, you will get an empty form that will allow you to enter the information for each case.
5. **Exit** - Click on to exit the Harkin Tracking System.

The following are instructions for navigating each selection.

Case List - All (to view or edit existing case):

The cases are listed by ascending order. To view a specific case, move the cursor to the front of the **Number** and click on the **View Details** button on the bottom of the screen. If you click on **Cancel**, you will go back to the previous screen. Or, you can click on "**File**", and then elect "**Close Form**" to take you back to the previous screen. When you click on **View Details**, the next screen should appear.

The screenshot shows a window titled "ORT System" with a menu bar (File, Edit) and a toolbar. The main area displays a table titled "Harkin Case List". The table has the following columns: Number, State, FID Number, Provider Number, Provider Name, and Contract Number. The first row is selected, and the "View Details" button is visible at the bottom right of the table area. Below the table, there is a record navigation bar showing "Record: 1 of 4" and a "Form View" label. The Windows taskbar at the bottom shows the Start button, open applications (Microsoft Word - AHARIN..., ORT System), and the system clock (02:10 PM).

Number	State	FID Number	Provider Number	Provider Name	Contract Number
CA101	CA	234523	18756	Health Care USA Bethesda	00410
PA101	PA	756452	23452	HMO Atlanta	03509
CA102	CA	45635	34523	George Washington Group Care	03542
54387	MD	45632	34234	HMO Georgia	34252

ORT System - [View/Edit Complaint]

File Edit

VIEW/Edit Harkin Case **Preview Report** **Cancel** **Save**

Complaint Number: FID Number: State:

Date Of Initial Contact: Date Complaint Closed:

Provider Name: Provider Number:

Provider Address: Amount Dispute:
 Amount Recovered:

Contractor Number: Action Taken:

Explanation:

Record: of 1 (Filtered)

complaint number FLTR NUM

Start Microsoft Word - AHARIN... ORT System - [View/...]

02:11 PM

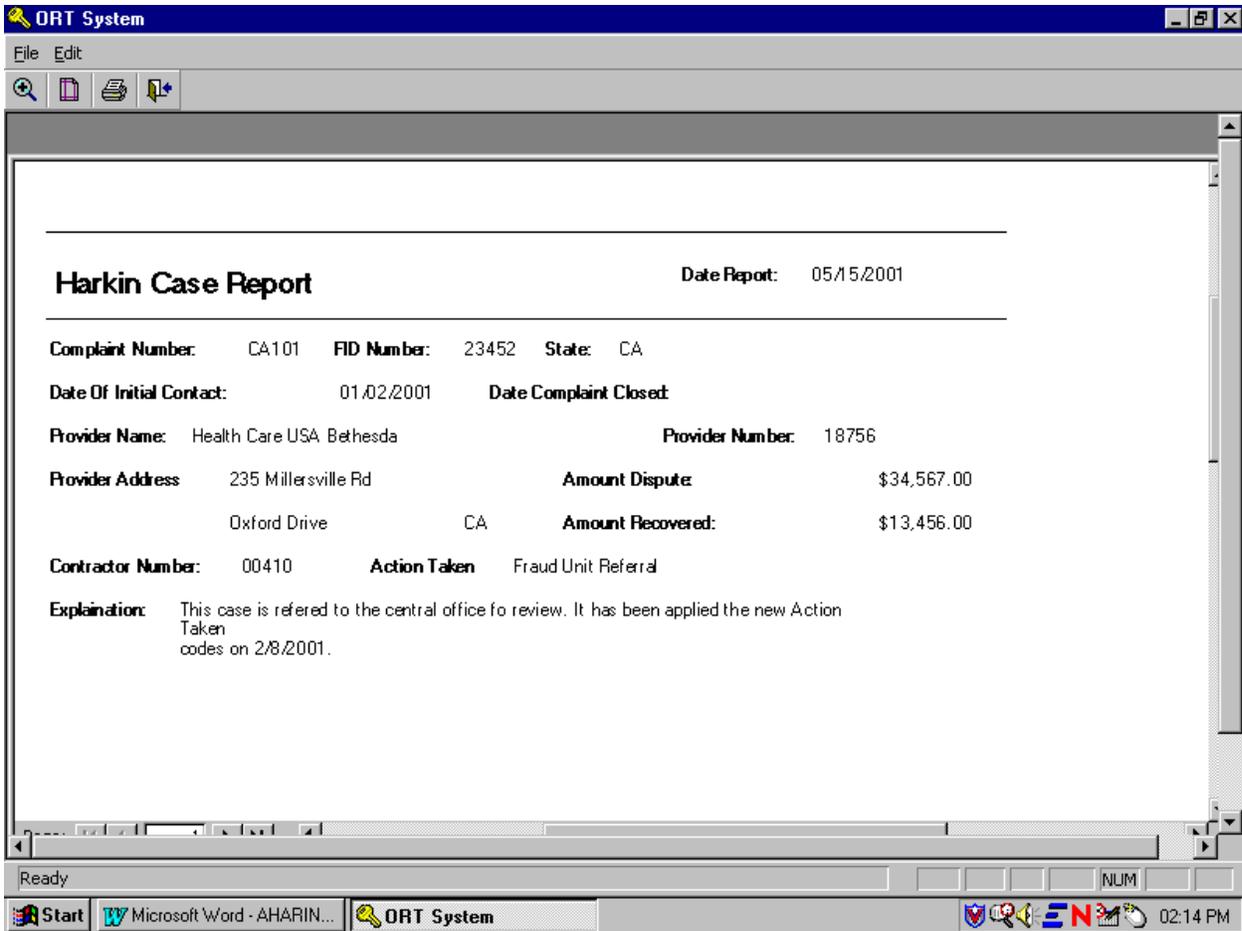
- Remember that the form allows for "Read only" access unless you have read and **write** capability. **If you have "Read only" access, you will not be permitted to alter the information on this form.** If you have "write" access, then you can edit and after you make changes, click on **Save** before you close the form.
- When you choose the **View Report** button, you will see the report in the **Details** format. To view the **Tabular** format, you should go to the **Report Menu** on the first screen (Harkin Tracking Menu) and choose the category and case number you want to view.



If you choose Report Menu, you will see this screen:

*You are given the option of viewing by **Detail Description** or **ATabular Format**. For example, if you want to view project CA101 you could choose. **Detail Description** format (click on **Specific Case**, then enter CA101 and click on **OK**), you will then see the preview report of CA101 as reflected in the next chart.*

*If you choose to view the **Tabular Format** for the project CA101, you would go to the **Tabular Format** category, choose **Specific Case**, enter the case number CA101, and click on **OK**. An example of the tabular format of the preview report for CA101 is given on the next page.*



*The tabular format contains 2 pages; you just click on the **right Arrow** on the bottom next to the **word page**, or **left Arrow** to get back to the previous page.*

*The following descriptions present the various options presented to you for viewing the cases. For example, **All Cases** will show you all the projects currently in the system.*

***View Report - Specific Case** -- Displays the **Detail Description** format of that case. The report will resemble the one displayed for case CA101 on Page 8.*

***Add New Case (complaint number):** (You will only see this button if you have Write access)*

ORT System

File Edit

Harkin Case Report

Tuesday, May 15, 2001

Complaint Number	FID Number	State	Date of Initial Contact	Date Complaint Closed	Provider Number	Provider Name	Provider Address
CA101	23452	CA	01/02/2001		18756	Health Care USA Bethesda	Oxford Drive Oxford Drive

Ready NUM

Start Microsoft Word - AHARIN... ORT System 02:16 PM

To enter new case (also referred to as complaint), begin by filling in "Complaint Number" by taking the existing project code (i.e. CA000) and adding subsequent case in sequential order (i.e. CA001, CA002, DC200, DC201, DC202, etc.) Fill in the remainder of the required information, then click on "Save" before you close the form.

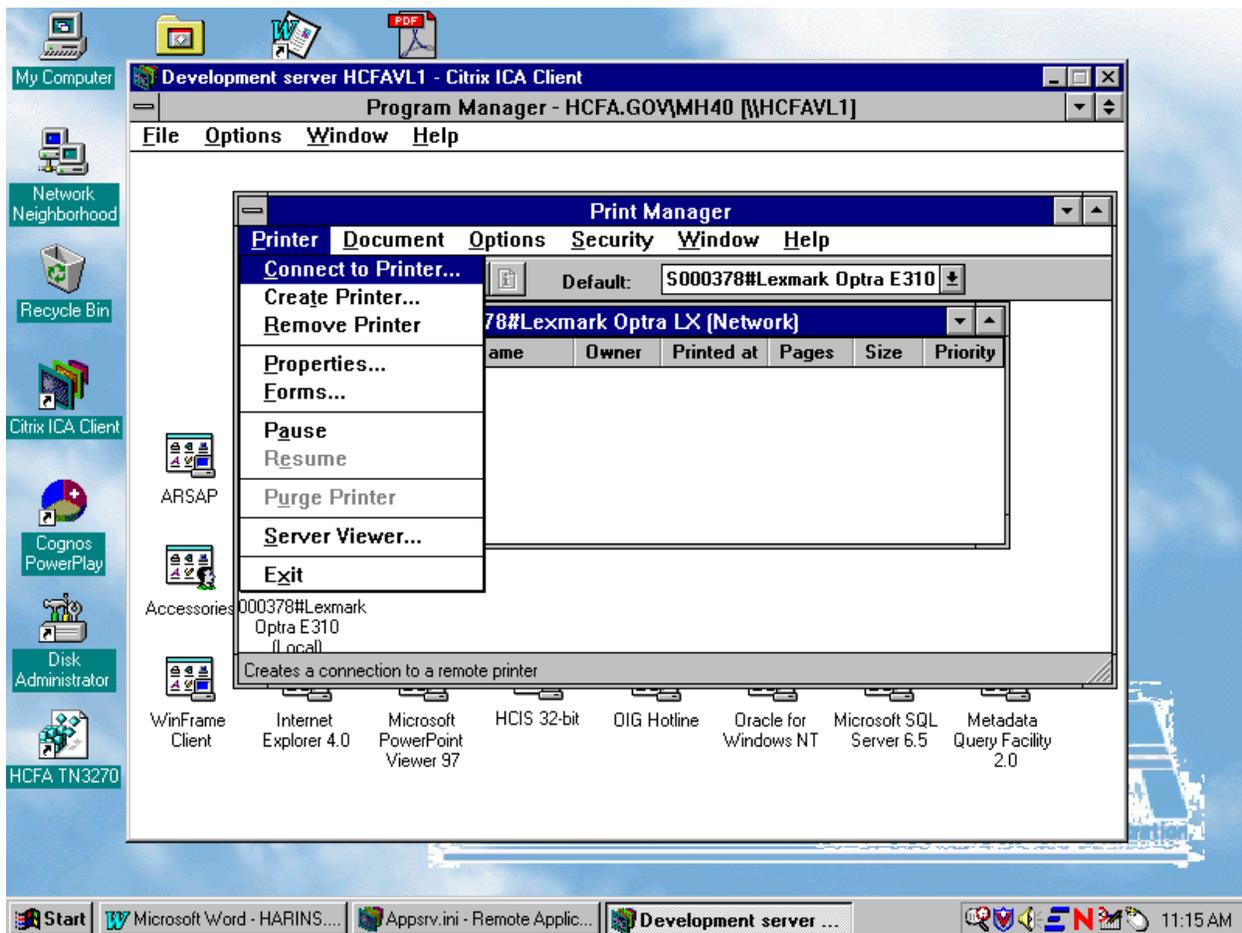
"Complaint Number" is a mandatory field and must be filled in when you want to add a new case.

Exit: *Click to exit the Harkin Tracking System.*

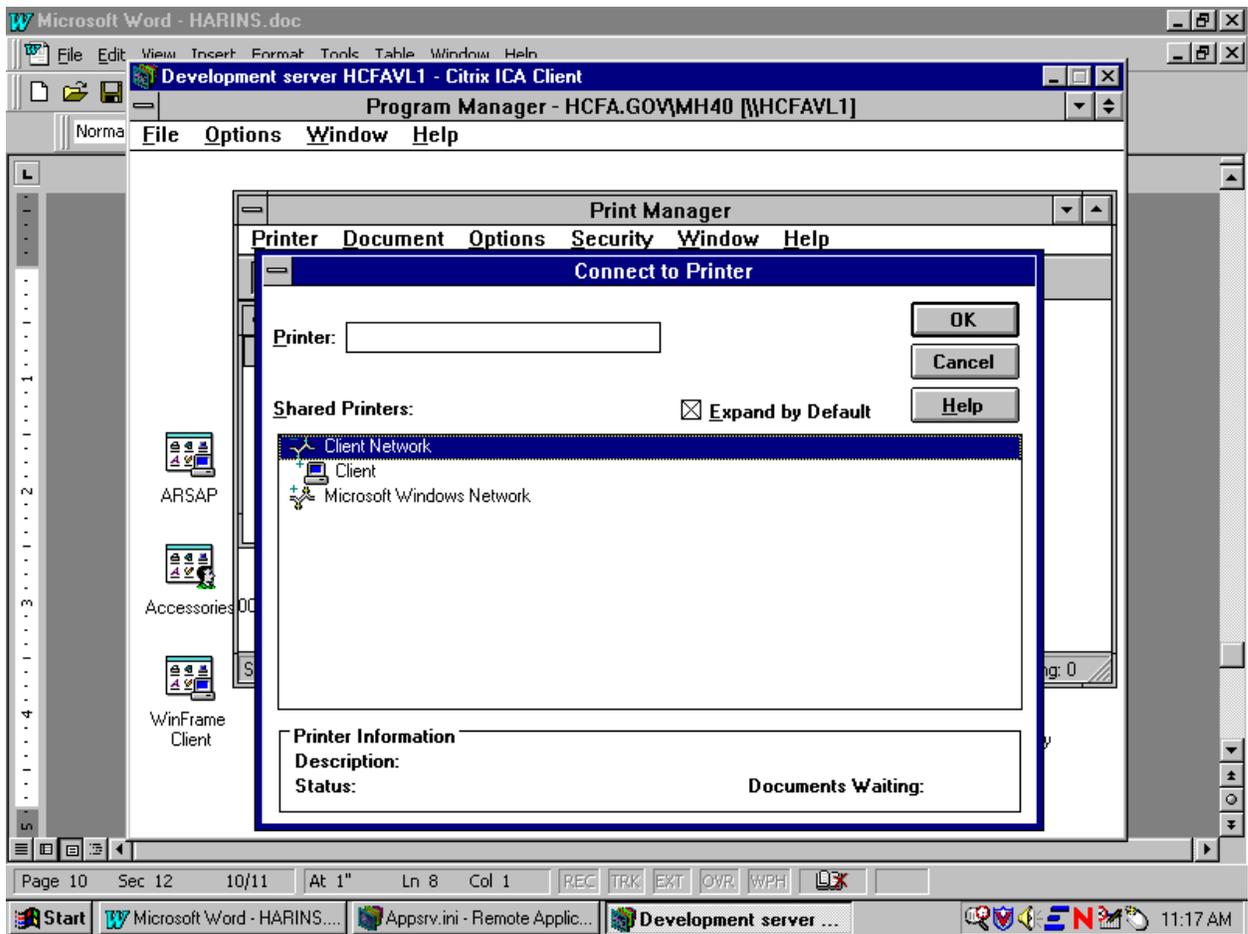
SET UP THE DEFAULT PRINTER ON WINFRAME

The Winframe Client is supposed to automatically create the default printer when you log on. If the default printer is not set, the system will indicate this and you will not be able to view the reports. The following section provides instructions on how to set the printer on the Winframe, however, you should set up the default printer for your local LAN before you log on to Winframe.

*After you log on the Winframe, click on group icon **Main**, click on **Control Panel**, click on **Printer**. Click on **Printer** on the **Menu**, and you will see the following screen:*

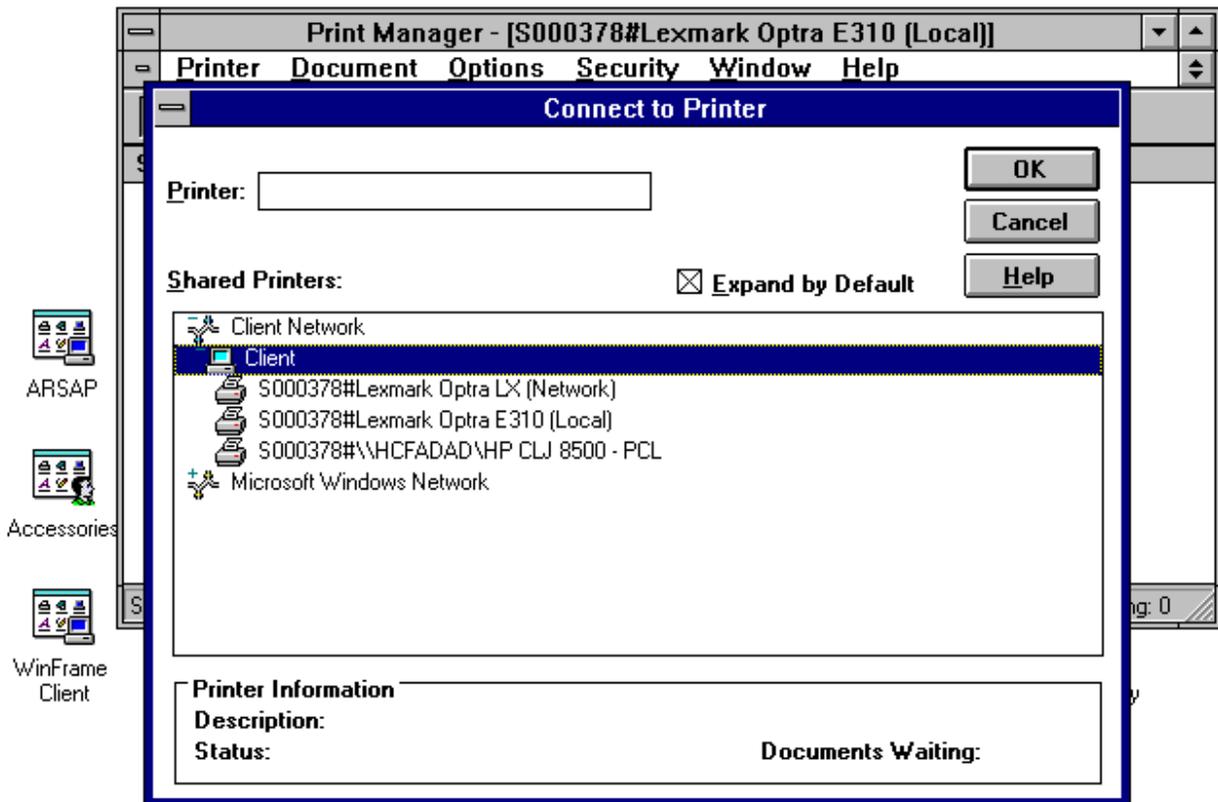


*Then click on **Connect to printer**. At this point you will have to wait because the Winframe will try to connect to the other printer server (indicated by hourglass on screen). The following screen will then appear:*



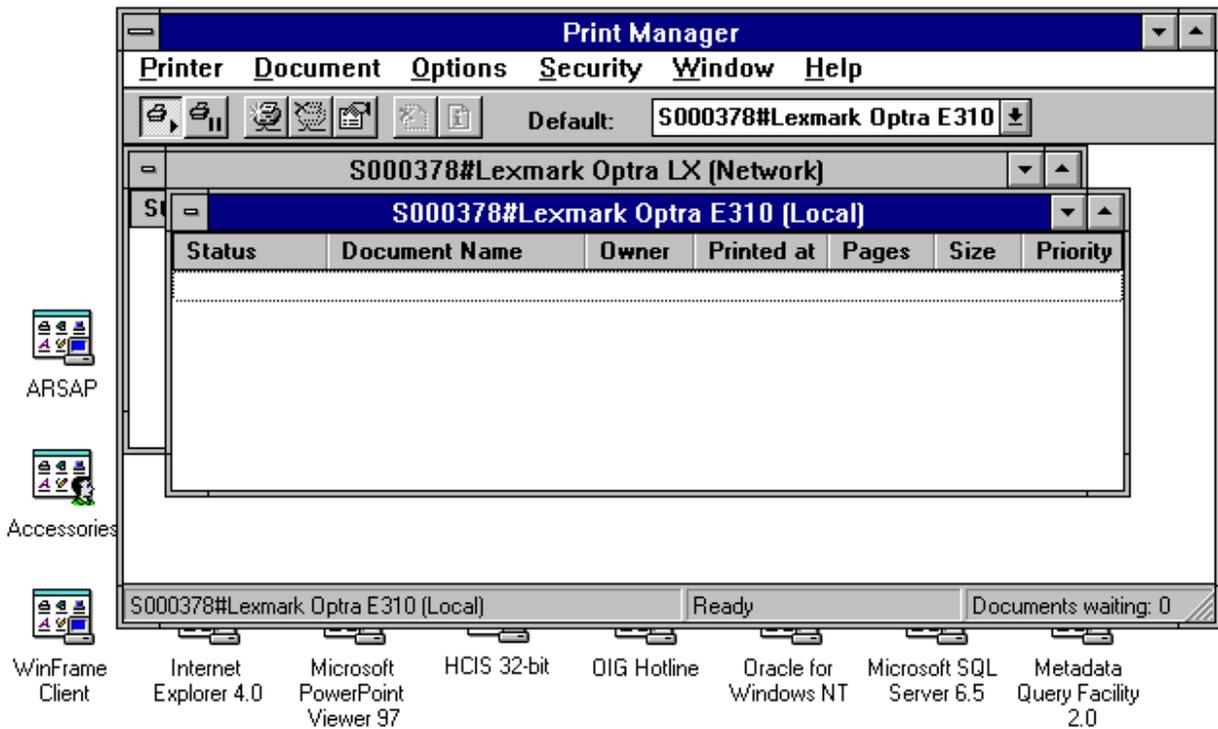
*Click on **Client Network** and then **Client**. At this point you will see the list of Printers, which are set up on your local PC. Each will be different depending on what type of printer you are connected to locally.*

Program Manager - HCFA.GOV\MH40 [\HCF AVL1]
File Options Window Help



*For example, if you have three printers connected locally, you will select a printer for the report to be sent to. Highlight the printer name, then click on **OK**. Click on **OK** for the next 1 or 2 windows and you will see the following screen displayed:*

*At this point you will see the printer you picked displayed on the **Printer Manager** window.*



This will set up your default printer on Winframe and you should be able to view the reports.

If you have any questions about the printer setup, please contact Binh Nguyen at (410) 786-3682.

Exhibit 33 – Harkin Grantee Model Form -- (Rev. 32, 10-25-02)

State (if not evident in name)

*Grantee Name
MODEL FORM*

Grantee Phone #

FID # _____

***HARKIN PROJECT FRAUD AND ABUSE COMPLAINT REFERRAL FORM
DATE:***

(insert information on contractors here)

From: (Your Name)

Organization:

County:

Address:

City:

State:

Zip:

*Phone: (With Area Code)
Applicable)*

Fax #

E-Mail (If

*Beneficiary Name:
Date of Birth:*

Medicare #:

Medicaid #:

Address:

Phone #: (With Area Code)

City:

State:

Zip:

Beneficiary Can Be Contacted at:

Between _____

a.m. and _____ p.m.

Name of Complainant (If Different From Beneficiary):

Address:

Phone #: (With Area Code)

City:

State:

Zip:

Complainant Can Be Contacted at:

Between _____

a.m. and _____ p.m.

Complaint Against: (Name of facility, provider, physician, lab, supplier, etc.) **Claim #** (If appropriate)

Date(s) of Service:
Business Address: _____ **Phone: (With Area Code)** _____

Provider Number: _____
City: _____ **State:** _____ **Zip:** _____

Please describe your complaint. If known, include procedure code and/or description of service, amounts billed, amount you paid, etc. You may continue on the next page if you need more room. If you feel you were billed for services or supplies that were not provided, continue with the non-rendered service section below.

Description of Complaint (Continued)

Non-rendered Services Section:

Did you see any provider that day? _____ **If yes, who? (Physician's Assistant, Nurse, Lab, X-ray Technician)**

Was the service(s) provided on another day? _____ **If yes, when?**

Have you ever seen the provider listed? _____ If yes, when?

Have you contacted the provider/supplier regarding this billing? Yes No

If yes, to whom did you speak and what was the result of the conversation?

Release of Information: Please read carefully and sign where indicated

*I, _____, hereby authorize
_____ and*

*(insert name of project) to discuss my complaint with _____
for the purpose of investigating possible fraud or abuse.*

I understand that, except for action already taken, I may revoke this authorization at any time. I also understand that a photocopy of this authorization has the same effect as the original. I further understand that the parties named above will not disclose this information to anyone else without my consent. This authorization expires one (1) year from the date on which it is signed.

Signature

Date

Important: Please attach the appropriate Medicare and/or Medicaid Explanation of Benefits relating to this incident. Also attach any other information you feel may be important to this complaint. When completed mail to: (insert name of project)